Senate Bill (SB) 553
Working Group on the Implementation Planning for the Incorporation of Nursing and Choices for Independence Waiver Services in the NH Medicaid Care Management Program

Public Working Session
August 23, 2016
10:30 a.m. – 12:00 p.m.
Philbrook Building, Room 119
Concord NH

Welcome/Introductions

Commissioner Jeffrey Meyers welcomed the working group and guests. He reviewed the agenda, including necessary changes to facilitate nursing services into managed care, and presentations by Michelle Winchester representing the Medical Care Advisory Committee and Denise Colby of the Quality Council. Doug McNutt of the Governor's Commission on Medicaid Care Management was scheduled to speak but unable to attend. A presentation from the MCM Commission will be made at the next SB 553 meeting on September 6, 2016. The opportunity for public input will be provided toward the end of today's meeting.

Commissioner Meyers made the following announcements:

1. The next meeting of the SB 553 working group will be September 6th; location to be announced.
2. The Governor's Commission on Medicaid Care Management scheduled for September is canceled due to schedules. The following meeting is scheduled for October 13, 2016.

Potential Changes to State Law as Required by SB 553

Commissioner Meyers summarized DHHS draft legislation submitted August 1st to Legislative leadership as required by SB 553. The draft identifies the Department's initial understanding of changes that may be necessary in order to pay for nursing facility services and CFI services under Medicaid managed care. In the Department's view, the only statutes to be changed are those pertaining to nursing facility services. Since SB 553 requires DHHS to draft the legislation so early on, the proposed changes do not reflect recently promulgated federal managed care regulations.

The Commissioner emphasized that the document is a starting point, subject to changes informed through a process that involves interested parties, members of the Legislature, and the next governor.

The statutes included in the draft legislation are: DRA statutes - RSA 84-C, Nursing Facility Quality Assessment statute; and RSA 84-D, ICF Quality Assessment; DHHS statutes - RSA 151-E, Long Term Care; and RSA 167, County Reimbursement - Limitations on Payments. DRA is amenable to the proposed changes in their statutes.

Under federal managed care regulations, a capitation rate is established for covered populations. Once long term care goes into managed care, rate cells for NF and HCBC will be established. No payments outside of the capitation rate can be paid under managed care. There can only be one Medicaid accounting unit to include Proportionate Share (ProShare) and MQIP (rather than making separating payments).

RSA 151-E:6-b currently contains a provision for a Memorandum of Agreement with the counties. However, there is currently no MOA in place. A formal process is needed whereby the Department works with stakeholders to share information throughout the process of developing payment rates. A public process will assure transparency in the development of the rates. It is hoped that a bill can be introduced at the start of the 2017 legislative session.

Questions:
In response to a question about rates for services other nursing facility services, the Commissioner stated that all rates to be developed will be subject to a transparent process.

In response to a question about the managed care rules, the Commissioner stated there will be a dedicated subgroup to further the discussion on the rules conversation as our meetings progress.

Presentation: Medical Care Advisory Committee (MCAC) Managed Care Requirements
Michelle Winchester, Chair of the MCAC, presented the MCAC's initial recommendations and concerns based on its Fall 2015 review of the NH-MCO contract relative to implementation of managed long term services and supports.

The MCAC is comprised of providers, consumers, and advocates, authorized under federal Medicaid law to advise the state's Medicaid program on policies and administration of the program. To date, the MCAC has provided input on managed care recipient rules, plan selection, plan enrollment, grievance procedures, and the like.

Ms. Winchester presented the high points of the MCAC's contract review.

1. A number of standards in the contract are not adequately defined. For example, the MCOs are required to develop "community integration plans." However, the contract neither defines the elements that comprise these plans nor the standards for approval. There should be a public process on definitions.

2. **Enrollment:** Case coordinator assignment is key for home and community based care. Questions raised include how care plans will be developed; and what will happen to consumers' existing care plans? The MCAC is concerned about client safety if the conversion creates delays in conducting face-to-face visit for longer than the required 60 days.

3. **Service Access:** "Equal access to services" is not defined. It resembles the Medicaid principle of "comparability," i.e. that Medicaid clients have comparable access to that of the general population, but does not state where the equal access provision comes into play. Will the MCOs' criteria go beyond what is already in NH's Medicaid rule, and what will be the public process?

4. **Care Coordination:** What is meant by "Care Coordination?" Though it is currently voluntary, it will become more of a mandatory process with the new CFI coordinator. This should be a conflict-free process. Otherwise, there's a built-in conflict on the part of the MCO that pays for services *and* establishes a care plan. The contract mentions the firewall, but does not describe the standards for a firewall.

Overall, the MCAC wants to know what the MCOs will be managing in the MLTSS area and wants to see a public process and a monitoring function.

Members of the working group and audience raised questions about comparability among the various types of waivers. DHHS will look at each waiver and consider changes to be made. Concerns were raised about expiration of provider licenses. DHHS has recognized the problem, extended contracts to ensure access to services. There will be no suspension of services.

Presentation: Developmental Services Quality Council Report Summary
Denise Colby, mother of a child with a disability, presented the findings of the Quality Council. The Quality Council was established in 2009 to provide leadership for systems review. In 2014, DHHS asked the Council to make recommendations for the transition to managed care.

Ms. Colby emphasized the importance of families' engagement in the development of a plan so that their concerns are reflected in the contract language. She stated that no one knows better than families what the challenges and needs are.

Sarah Aiken of Community Bridges, described the collaborative effort with multiple groups and DHHS to develop contract language. The Report includes the top 20 issues that are critical to families. Families asked for ease in accessing services; that relationships remain intact; service coordination, care coordination, functioning IT system, accurate billing. The Quality Council's meetings are open to the public and posted on their website a
http://www.dhhs.nh.gov/dcbcs/bds/qualitycouncil/documents/2016qcmeetingschedule.pdf

Commissioner Meyers added that he will address the public procurement process at the next SB 553 meeting on September 6th. The current contract expires June 30, 2017. In addition, the principles and recommendations of the Governor's Commission on Medicaid Care Management will be presented. Once finalized, one or more Commission members will present their recommendations to this group by late Sept/early October. Future meeting dates will be published soon.

Once the remainder of presentations to the SB 553 Working Group are completed, the group will focus first on CFI and what CFI should include. This will be done in collaboration with those interested in participating in the process. Input is desired.

Public Comments and Questions Answered by Commission Meyers
Q: Will there be a discussion on Step 1 struggles so mistakes are not repeated?
A: Arrangements will be made to have one or more CFI providers discuss lessons learned.
Q: Is there room in the process to learn from other states?
A: We need a presentation on what works and doesn't work in other states, and at the same time, respect the differences between our states.
C: The working group should think about the Counties' perspective, i.e. what does managed care really mean? In taking the whole person approach, recognize that one organization cannot meet the needs of all individuals. Long term care services will have to be strengthened with technology and data because the present model is not sustainable. Learn from successes and failures.
C: Consider including representation of older adults to adequately represent a large portion of the population to be served. To find a representative, look to nursing facilities' residential councils.

Commissioner Meyers closed the meeting at 12:00.